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WHY INDIA NEEDED A NATIONAL MENTAL HEALTH PROGRAMME: AN OVERVIEW OF ORIGIN AND EVOLUTION

Community Medicine

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ABSTRACT

India was one of the pioneer countries in the developing world to launch its National Mental Health Programme in 1982 with vision to promote mental health in the community and providing treatment at primary health care level. NMHP has grown over the years, learning from its experience and evolving to meet the ever-growing burden of mental health disorders. Some of the pillars of this programme have been launch of DMHP, National Mental Health policy 2014 and Mental Health Care Act 2017. In order to achieve goal of Universal Health Coverage, need for strengthening of NMHP becomes of utmost importance.

KEYWORDS

National Mental Health Programme, District Mental Health Programme, Bellary Model, National Mental Health Policy, Mental Health Care Act

INTRODUCTION

Health is one of the basic pillars in growth and development of individuals, community, societies and country at large. WHO defines health as, Health is a "state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1] The maxim, "there is no health without mental health" underlines the fact that mental health is an integral and essential component of health. With changing health patterns in recent times, there has been a pragmatic shift in health care delivery systems in India, with mental health disorders, coming to limelight. These disorders contribute significantly in morbidity, disability and even mortality among those who have been affected. As per NMHS 2016, the overall weighted prevalence for any mental morbidity was found to be 13.7% lifetime and 10.6% current mental morbidity. The age group between 40 and 49 years was predominantly affected (psychotic disorders, bipolar affective disorders [BPADs]), depressive disorders, and neurotic and stress-related disorders.[2] In another study titled "The Burden of Mental Disorders Across the States of India: The Global Burden of Disease Study 1990–2017", published in The Lancet Psychiatry had estimated that in 2017, there were 197.3 million people with mental disorders in India which translates to 14.3 per cent of the total population of the country. The contribution of mental disorders in the total DALYs in India increased to 4.7 per cent of in 2017 as compared with 2.5 per cent in 1990.[3]

Though many studies have been conducted in recent times to estimate the magnitude, pattern and extent of mental health disorders prevalent in India, it is not easy to estimate the social and economic burden that mental health issues entail. Over years, various measures have been taken by Government of India to tackle the increasing burden of mental health disorders in our country. In this article, we will review the history, evolution and current status of mental health policies and programmes of India which have been undertaken over years to curb this problem which is on rise.

Post Independence Scenario

Post-independence, there was change in care of mentally ill patients, i.e., there was shift from having separate mental hospital bases to general hospital settings. This shift allowed for better care of mentally ill patients, especially in urban areas, which involved hospitalization for shorter period of time. Further there was change in the type of caregiving, with primary caregivers being family members as compared to traditional long-term asylum-based care isolated from family. This allowed for upliftment of barrier for seeking treatment among people with less severe forms of mental illnesses. By 1970s, along with establishment of specializations and trainings for health care personnel, the private sector for care of mentally ill grew too. The main lacuna was that this shift was predominant in urban areas, with rural areas still having traditional beliefs of supernatural origin for psychiatric illnesses. This parity between urban and rural areas and lesser resource allocation as compared to other illnesses, left a lot to be desired. With growing awareness regarding mental illnesses in community and awareness regarding its wide prevalence led to further advances in terms of care, from hospital to community bases and specialist to generalist to cover the gap between "need" and "available services".[4] This issue of organisation of mental health services in the community was brought to highlight in early 1970s by the Department of Psychiatry, at the National Institute of Mental Health and Neurosciences. To address it, 'Community Mental Health Unit' was designated to start within the constraints of limited trained personnel, facilities and financial supports.[4]

Conception Of A National Mental Health Programme

In 1974, an expert committee of the WHO, on organisation "of mental health services in developing countries" held at Addid Ababa lead to inception of idea of national mental health programme and urged its member states to recognise mental disorders as a problem of high priority for the individual, for the community and for national development and made several important recommendations.[5] The committee recommended that:

- "Countries should, in the first instance carry out one or more pilot programmes to test the practicability of including basic mental health care in an already established programme of health care in a defined rural or urban ' population".
- It also emphasized on "training programmes, including a simple manual for the training of health workers should be devised and evaluated".[4][5]

In the backdrop of fulfilling this resolution, World Health Organization (W.H.O.), Mental Health Division under the leadership of the then Director Dr. Norman Sartorius had incepted the idea of national mental health programme.[6] In lieu with developing strategies for mental health in developing countries and implementation of recommendations of 1974 expert committee,

1) A pilot project on developing "Community Mental Health Unit" was first started in around 200 villages around the Sakalwara rural mental health centre (with population around 1,00,000) by NIMHANS in 1975 with vision of developing simpler ways for identification and management of people with mental illnesses, evaluating and carrying out suitable training programmes in basic mental health care for different categories of personnel via developing mental health education material. The overall experience of Sakalwara Project led to development of strategy

for providing of Mental Health care to the rural areas through the already existing primary health care system.[4]

2) A multi-national Project "Strategies for Extending Mental Health Care (1975–1981) was launched in the seven developing countries (Brazil, Colombia, Egypt, India, Philippines, Senegal, Sudan)" to implement the 1974 WHO recommendations at the level of general health care. [6] The department of Psychiatry at PGIMER Chandigarh was as selected as the centre in India and the model was developed in Raipur Rani Block of Haryana. The model focused on integration of mental health care services with general health care services and orientation of health care professionals to basic mental health care. These models provided the framework for decentralization of mental health care. The impact of mental illnesses on the family and community were assessed which further underlined the importance of broadening the base of services to be provided along with general health services and the involvement of community to overcome the social barriers. [7][8][9][10] These global commitments and success of local projects laid foundation for a mental health programme that can be implemented at national level.

Birth Of The National Mental Health Programme

As mentioned above, the success of pilot studies and to fulfil commitment of Health for all became the basis of drafting the National Mental Health Programme (NMHP) in 1981. The draft was formulated by an expert drafting committee and was further reviewed and revised in two national workshops (July 1981 and August 1982 respectively) held in New Delhi by senior psychiatrists and other stakeholders. The draft was then put before Central Council of Health and Family Welfare (CCHFW) and was later adopted by the Government of India in August, 1982 making India one of the pioneer countries in the developing world to launch Its National Mental Health Programme.[7]

The objectives of the NMHP were[11]:

- To ensure availability & accessibility of minimum mental health care for all (particularly the vulnerable & underprivileged sections)
- To encourage application of mental health knowledge in general health care and in social development
- To promote community participation in the mental health services development and to stimulate self-help efforts in the community.

To realize these objectives the following approaches were envisaged:

- Integration of the mental health care services with the existing general health services.
- Utilization of the existing health services infrastructure to deliver minimum mental health care services.
- Provision of appropriate task oriented training to the existing health staff.
- Linking of mental health services with the existing community development programs.

Evolution Of NMHP And Birth Of DMHP

Though the programme was in place for mental health, there were big issues faced in its implementation at ground and community level. The key issues faced were [12]:

1) The service: Lack of feasibility in real life as compared to pilot project settings
2) Service deliverers: lukewarm reception by psychiatrists especially by private practitioners
3) The service users: Lack of community participation and poor seeking behaviour for mental health illnesses
4) Lack of financial estimates or budgetary allocation and lack of clarity regarding who should fund the programme – the central government of India or the state governments.

As the feasibility of caring the programme on national level was being tested, the idea to make district as the implementation and administrative unit for the programme was conceptualised. So, NIHMANS undertook a pilot project, also known as Bellary Project, in 1985-1990. As suggested by name, it was carried out in Bellary district of Karnataka to assess the feasibility of selecting district as the implementation and administrative unit for the programme. Specific objectives of DMHP were:

- To develop and implement a decentralized training program in mental health for all categories of health personnel in a way that would be the least disruptive to on-going general healthcare activities.
- To provide a range of essential drugs such as antipsychotics, antidepressants, anticonvulsants, and minor tranquilizers for the management of PWMI
- To develop a system of simple recording and reporting of care by mental health personnel
- To monitor the effect of service of the mental health program in terms of treatment utilization and outcomes
- To reduce the stigma by bringing about a change of attitude through public health education Treatment and rehabilitation of patients within the community by adequate provision of medicines and strengthening the family support system.

In addition to activities carried out at primary level, a mental health team was constituted at district level, consisting of a psychiatrist, clinical psychologist, a psychiatric social worker and a statistical clerk. The concept of referral of patients from primary health centres to district mental clinic was established. The psychiatrist posted at the district hospital had the keep job of reviewing and treating the patients referred from the primary health centres. The provision of hospitalization for around 10 patients at a time at the district hospital for brief in-patient treatment was provided. Monthly meetings between primary health centre medical officers and district health officers were held every month and the mental health programme was reviewed monthly at the district level during these meetings. The study was carried out till 1990 to see if the Bellary model was successful in providing mental health care services at both primary and district level. It was concluded that:

Mental health care delivery was possible in the primary health care setting if primary health care workers and doctors were adequately trained to provide mental health care services with appropriate supervision.[13][14][15]

Progression Of Dmhp Over The Years: (1997-2017) [16]

The success of Bellary model paved the path for introduction of District Mental Health Programme in 1996 which was launched in 4 districts under NHMP. The main objective of DMHP was to provide Community Mental Health Services and integration of mental health with General health services through decentralization of treatment from Specialized Mental Hospital based care to primary health care services. Table 1 highlights the progression of DMHP over the next five years plans till 2017.

Table 1: Progression of DMHP over the years: (1997-2017)

DMHP in 9th five year plan (1997-2002)	***DMHP in the 10th Five-Year Plan (2002–2007)***	***DMHP in 11th Five-Year Plan (2007–2012)***	***DMHP in 12th Five-Year Plan (2012–2017)***
The District Mental Health Program (DMHP-1996) Based on 'Bellary Model' with the following components: 1. Early detection & treatment. 2. Training 3. IEC: Public awareness generation. 4. Monitoring: Starting with 4 districts in 1996, the program was expanded to 27 districts by the end of the IX plan	NMHP: re-strategized in the year 2003 with the following components: 1. Extension of DMHP to 100 districts 2. Up gradation of Psychiatry wings of Government Medical Colleges/ General Hospitals 3. odernization of State Mental hospitals extended to 110 districts, with up gradation of psychiatric wings of 71 medical colleges/general hospitals and modernization of 23 mental hospitals	revitalized with the provision of the following: 1. Program officer (a psychiatrist) and family welfare officer (to work with the psychiatrist) in each district 2. Ten beds for acute care 3. Essential drugs at PHCs and more advanced drugs 4. Training programs for medical officers 5. The Manpower development scheme (Scheme-A & B)	Mental Health Policy Group (MHPG) appointed by the MOHFW 2012 draft for DMHP (under the 12th Five Year Plan)

Dmhp In 12th Year Plan And Mental Health Policy

In 2014, National Mental Health Policy of India was drafted to promote mental health, prevent mental illness, enable recovery from mental illness, promote de-stigmatization and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life-span within a rights-based frame work. The policy emphasized some old concepts and added new initiatives. The key provisions have been listed in Table 2.[17][18]

Table 2: Key provisions of Mental Health Policy 2014

Services available at Primary Health Centers: Outpatient services; Counseling services in accessing social care benefits; Pro-active case findings and mental health promotion activities Manpower; Community Health Workers (Two)
Services available at Community Health Centers: Outpatient services & inpatient services for emergency psychiatry patients with a 10 bedded inpatient facility; Counseling services. Manpower: Medical Officer, Clinical Psychologist or Psychiatric Social Worker
Out-Reach Component: Satellite clinics: 4 satellite clinics per month at CHCs/ PHCs by DMHP team
Targeted Interventions: Life skills education & counselling in schools, College counselling services, Work place stress management, and Suicide prevention services
Awareness camps and **Community participation**: Linkages with Self-help groups, family and caregiver groups & NGOs working in the field of mental health
Sensitization and training of health personnel
PPP Model Activities: Day Care Centre to provide rehabilitation and recovery services to persons with mental illness and Residential/ Long term Continuing Care Centre for Chronically mentally ill individuals
Research & Survey: For carrying out research & survey in different regions of the country in the field of mental health.
Monitoring & Evaluation: Standard formats for recording and reporting have been developed and circulated
IEC: The central level dedicated website to provide information on mental health resources, activities, plans, policy and programmes.
Mental Health Information System: An online data monitoring system to facilitate bilateral communication between participating units.
Training/Workshops: Trainings for master trainers from each state/UT who shall further train DMHP team and other staff working in the field of mental health

Recent Updates Post 12th Five Year Plan

- Though the 12th year plan ended in the 2017 and the Five-Year Plan Programme was discontinued, the DMHP continues to be implemented based on the guidelines issued in 2015 under the 12th year plan.
- Mental healthcare Act was passed in 2017 with view "to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfill the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto." This Act superseded the previously existing Mental Health Act, 1987 that was passed on 22 May 1987. [19] The salient features of the Act are listed in Table 3.

Table 3: Salient Features Of Mental Healthcare Act

- It states that mental illness be determined "in accordance with nationally and internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Central Government."
- No person or authority shall classify an individual as a person with mental illness unless in directly in relation with treatment of the illness.
- Decriminalization of attempted suicide which was punishable under Section 309 of the Indian Penal Code
- Restriction on usage of Electroconvulsive therapy (ECT): to be used only in cases of emergency, and along with muscle relaxants and anesthesia.
- ECT prohibited to be used as viable therapy for minors.
- MHCA also places obligation over insurance provider to cover mental illness along with physical illness with Insurance Regulatory and Development Authority of India (IRDAI) issuing circular, directing insurance provider to cover mental illness as well.
- Responsibilities of other agencies such as the police with respect to people with mental illness has been outlined along with vouching to tackle stigma of mental illness.

- In 2018, an effort to strengthen the delivery of primary health care in India based on provisions under the National Health Policy, 2017, Ayushman Bharat was launched by the Government of India in 2018. The programme envisions to create 1,50,000 Health & Wellness Centres (HWCs) by transforming existing Sub-Health Centres and PHCs to deliver comprehensive primary healthcare. The HWCs are envisioned to provide comprehensive health care services, including screening and providing basic management of mental health conditions, i.e., diagnosis, counselling, provision of medicines and referral services.[20]

Current Status Of Mental Health Services And NMHP

In response to a question raised in the Lok Sabha, in September 2020, the government reported that it was supporting the implementation of the DMHP in 692 districts of the country.[21] Though many provisions have been made over last few decades, there is still huge lacunae in mental health workforce in India and mental health professionals as compared to the number of people suffering from mental health issues. As per WHO report (2019), there are 0.75 psychiatrists against the desired number of 3 psychiatrists. Further, there are 0.067 psychologists working in the mental health sector against the desired ratio of 1.5 per 1,00,000 population, as per WHO report (2019). Similarly, the country has only 1,500 psychiatric nurses against the desired requirement of 3,000.

CONCLUSION:

As NMHP completes its four decades, many lessons can be learnt from the mistakes and successes of the programme. Though the programme has understanding of the problems with aims and objectives set to meet the goals, there is lack of robust planning and execution. This can be attributed to lack of fund allocation and utilization by the states, lack of enthusiasm of the PHC professionals that has led to the poor implementation of the programme at ground level, inability to implement Bellary model in all districts of India and lack of monitoring and evaluation. Though there is a lot of work that needs to be done, one can have hope that with recent changes in Mental Health Care Act and Ayushmann Bharat, new life can be breathed in the programme as the need for caring for mental health is surely needed, as evident in recent epidemic. The health system needs to be ready to meet the inevitable rise of mental health disorders.

Conflict Of Interest: None.

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